STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

Internal Medicine Associates of Mt. Clemens
and
Jerome Finkel, M.D.,
Petitioners

Case No. 10-763-BC
Docket No. 2010-132

v

Blue Cross Blue Shield of Michigan,
Respondent

Issued and entered
this 24th day of June 2011
by R. Kevin Clinton
Commissioner

FINAL DECISION

I. BACKGROUND

This case concerns a 2008 audit by Blue Cross Blue Shield of Michigan of one of its participating providers, Internal Medicine Associates of Mt. Clemens (IMA). Based on its audit findings, BCBSM concluded it had erroneously paid the provider for several medical tests known as "cardiac computed tomography angiography" or "CCTA." BCBSM demanded repayment of $8,738.80 from the provider.

The provider disputed BCBSM's audit findings. A Review and Determination proceeding was held by the Commissioner's designee[1] who concluded that BCBSM had violated section 402(1)(e) of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), MCL 550.1402(1)(e). The Commissioner's designee also concluded that BCBSM was not entitled to recover the funds in question.

The decision was appealed to the Commissioner by BCBSM. A contested case hearing was held and a proposal for decision (PFD) was issued on February 19, 2011. The PFD reached the same conclusions as the Review and Determination. Neither party has filed ex-

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1. See section 404 of the Nonprofit Health Care Corporation Reform Act of 1980, MCL 550.1404.

ceptions to the PFD. It now remains for the Commissioner to adopt or reject the recommendations found in the PFD.

II. FINDINGS OF FACT

A. FINDINGS OF FACT FROM PFD

The factual findings in the PFD, other than those identified below, are in accordance with the preponderance of the evidence and are adopted. The findings of fact below are not adopted.

1. Paragraph 19 is not adopted because it is merely a restatement of the position of one of the parties and is, therefore, not a finding of fact.

2. The first two sentences of paragraph 26 are not adopted because they are speculative in nature.

3. Paragraph 31 is not adopted because it simply restates a portion of the Review and Determination which is already a part of the record (Respondent Exhibit 11).

B. ADDITIONAL FINDINGS OF FACT

Based upon the record in this matter, the Commissioner makes the following findings of fact in addition to those adopted from the PFD. To the extent any of the findings of fact adopted from the PFD are inconsistent with the findings below, the PFD findings are superseded. The Commissioner finds that:

1. BCBSM made timely payment to IMA of the claims for CCTA which are the subject of this hearing.

2. The BCBSM audit was started and concluded in a timely manner consistent with the requirement of the Provider Agreement which limits actions to initiate recovery of overpayments to two years from the date of payment, except in instances of fraud.

3. There was no evidence of fraud in the presentation of the claims in question.

III. ANALYSIS

The details of the claims at issue are found in BCBSM's Patient Refund Credit Report (part of Petitioner Exhibit 8). BCBSM audited 44 claims for CCTA testing (identified as procedure "0144T" in Exhibit 8). The claims were all paid by BCBSM within two weeks of the date of service. Payment for each service ranged from $29.76 to $350.00 with the typical charge being $200.00. The earliest charge identified in the audit was for a CCTA test on January 10, 2008; the latest test occurred on July 17, 2008.

BCBSM sought to recover a total of $8,738.80 from IMA. In a September 4, 2008 letter to IMA (part of Petitioner Exhibit 8), BCBSM explained the reason it felt repayment was required:

> [BCBSM] recently discovered that CCTA services reported were billed and paid incorrectly to non-participating consortium providers. We are writing to recover these overpayments. The enclosed listing identifies each incorrect payment for member services rendered. Please see enclosed *Record* article (July 2008) regarding BCBSM reimbursement policy for Cardiac Computed Tomography Angiography (CCTA).
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> Prior to launching the coronary tomography angiography initiative program in July 2007, [BCBSM] did not reimburse for these services. To be included in the CCTA program participants must meet application criteria. The current application process closed July 31, 2008. After this date, new applications will be accepted annually.

The relationship between BCBSM and IMA is governed by a "Physician and Professional Provider Participation Agreement" (Respondent Exhibit No. 2) which is a standard contract that BCBSM requires of all its providers. Addendum H of the Agreement contains an "audit and recovery" provision which includes this clause:

> BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary....

In reviewing the various communications between BCBSM and IMA, it is clear that the audit dispute concerns benefit criteria rather than issues of medical necessity (BCBSM has not disputed the medical necessity of the CCTA tests). The term "applicable benefit criteria" is not defined in the Agreement. There is no discussion in the PFD or Review and De-

termination concerning this term. It is necessary, therefore, to establish what is meant by "applicable benefit criteria" and how that term applies to this dispute.

Each party has offered its own argument as to the standards that should be used to determine whether the disputed claims should be covered. According to BCBSM, the appropriate standard is described in *The Record*, a newsletter distributed to BCBSM providers. In contrast, IMA's witness, Dr. Finkel, testified that he relied on BCBSM's web site for providers, "webDENIS" to determine whether IMA was qualified to bill for the CCTA procedures it performed. Dr. Finkel testified, without contradiction, that when the claims were submitted, BCBSM paid the claims. This is certainly correct since it is these same claims which BCBSM has now attempted to recoup.

Both *The Record* and webDENIS can be viewed as "applicable benefit criteria." Both are used to govern when a particular benefit will be paid.

If *The Record* was the sole source of such information, it would be clear to providers what the coverage limits were for this procedure. However, Dr. Finkel learned from some of his patients that they were able to submit claims directly to BCBSM and be reimbursed for the procedure. Dr. Finkel then called BCBSM to determine if the claims procedures for CCTA tests had been changed. The individual he spoke to was unable to give him the answer to his inquiry but did refer him to webDENIS.

When Dr. Finkel checked the coverage available for the procedure through the webDENIS system, he learned that the system did indicate coverage would be provided. His practice group then began to submit CCTA claims to BCBSM and, as noted above, the claims were paid.

IV. Conclusions of Law

A. Conclusions of law from PFD

For the reasons noted below, the following conclusions of law stated in the PFD are not adopted.

1. "[BCBSM] has not shown that the refund request...constitutes mistaken payments to Petitioner."

The issue to be resolved is whether the claims in question should be recovered because they did not meet BCBSM's "applicable benefit criteria" not whether a mistake had been made. In *Kilpatrick, et al v BCBSM*, 04-394-BC, (2005), BCBSM, after a provider audit, sought to recover claims payments from several providers for overpayments made as a result of an error in BCBSM's computer system. The Commissioner ruled that BCBSM could not recover the payments because the providers had reasonably relied, to their detriment, on the claims being correctly paid.

In the present case, the Commissioner finds that *The Record* and BCBSM's webDENIS system are both legitimate sources to be utilized by providers to determine if coverage is available. Both are the creation of BCBSM and both are controlled and maintained by BCBSM. The hearing record does not establish that one source is superior to the other in determining what services are payable by BCBSM. They are both, therefore, sources for determining BCBSM's "applicable benefit criteria." Under the standards in *The Record*, the claims payments should not have been made. Under the webDENIS system, the claims were paid. BCBSM is responsible for both sources of information.

Issues of *The Record* show an evolving policy regarding CCTA, from a very restrictive policy reimbursing only hospitals to a broader acceptance of claims from providers and hospitals within an expanding provider consortium. It would be perfectly reasonable for IMA to conclude, based on webDENIS information, that CCTA claims were being accepted from a still broader group of providers.

2. Respondent has failed to "affirm or deny coverage of a claim within a reasonable time after a claim has been received" contrary to section 402(1)(e) of [Act 350]."

BCBSM did not fail to affirm the claims in question – the claims were paid within two weeks of the service being provided. The audit that followed was executed within the time frames permitted for claims payment audits set out in the Provider Agreement. There is no evidence in the record which would support a conclusion that BCBSM did not "affirm or deny coverage of a claim within a reasonable time after a claim has been received." As a consequence, BCBSM is found not to have violated section 402(1)(e) of Act 350.

B. ADDITIONAL CONCLUSIONS OF LAW

Based upon the statutory law and case law applicable to this matter, the Commissioner makes the following conclusions of law in addition to those adopted from the PFD.

To the extent any of the conclusions of law adopted from the PFD are inconsistent with the conclusions below, the PFD conclusions are superseded. The Commissioner concludes that:

1. BCBSM has failed to establish that IMA should be required to reimburse BCBSM for the claims already paid and which were addressed in the BCBSM audit.

2. There is no evidence that BCBSM's conduct violated section 402(1)(e) of Act 350. (For a similar result concerning the question of section 402 violations, see the 2006 Final Decision in *Daly v BCBSM,* Case No. 04-395-BC, a BCBSM provider audit case in which the Commissioner concluded that BCBSM had not violated section 402.)

V. ORDER

It is ordered that BCBSM is not entitled to the refunds it sought in this matter.

R. Kevin Clinton
Commissioner